better nurse, however, the question should be whether there is evidence that it makes a less efficient one. Perhaps the new UK Central Council for Nursing, Midwifery, and Health Visiting (due to come into existence later this year) could consider issuing some well-informed advice to schools of nursing with regard to this and similar questions. The CMB did this sometime ago, but while I would disagree with some of its recommendations (for example, with regard to epilepsy it would seem sensible for them to be in line with the legal requirements for application for a driving licence) it was a step in the right direction. Such advice would, hopefully, help to dispel some of the prejudice which obviously now exists and the resultant situation in which some schools of nursing appear to be doing their own, maybe subconscious, medical screening, in addition to their selection of suitable candidates.

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SIR,—Miss H K E Browning's letter (26 July, p 307) about careers for diabetic girls in nursing makes sad reading. I believe that, just as nurses are often the best judges of a doctor's competence, doctors know a lot about what makes a good nurse; and instead of defending our separate territories in the spirit of professional apartheid we should be using our complementary experience of medical practice in choosing the best candidates for both professions. I would certainly welcome a nursing colleague in the task of selecting medical students and residents and I believe that nursing should be represented as of right on the GMC. Moreover, I am an advocate of a year's nursing experience as an essential qualification for entry to medical school alongside the requisite academic achievements.

It is my view that given two candidates for medicine or nursing the one with personal experience of what it is like to be on the receiving end of medical care should be given preference; and the same argument might well be applied to our choice of receptionists, telephonists, porters, and other ancillary workers. Such a policy would help to make hospitals the therapeutic communities which at present they are not, either in spirit or in structure. Professional status is conferred for the sake of the clients not the workers, whose privileges are granted in order to make it easier for them to discharge their responsibilities.

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Generic prescribing

SIR,—In your issue of the (19 July, p 230) Dr B Jarman reiterated the savings that could be made through prescribing drugs by their generic names, and Dr G P Walsh (p 232) recommended the American scheme. This latter could be readily introduced into Britain by offering two places where the doctor could sign the Health Service prescription: those signing on the left would expect the proprietary drug to be supplied, while those signing on the right would permit the pharmacist to dispense the generic equivalent.

I am considering, however, having all my FP10 NHS prescription forms over stamped with "The generic equivalent may be supplied," and would value guidance from readers on the ethical and legal aspects of such a stamp.

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Treatment of axillary hyperhidrosis

SIR,—We are rather concerned that the report by Mr C R W Rayner and others (10 May, p 1168) may prejudice others against the use of the excellent treatment with 20% aluminium chloride hexahydrate.

They reported that after two weeks, 24 out of 38 patients had obtained considerable relief, a response rate of over 68%, although five of these patients apparently did not find the treatment acceptable. "After six months, only six out of the original 19 with an effective initial response had sustained relief." What the authors imply here is that six out of this original group who persisted with treatment for two weeks were then free of axillary hyperhidrosis for a further six months without any further treatment. A further nine patients were controlled by twice-weekly applications, and another required treatment only once a fortnight, surely an acceptable frequency of treatment for even the least compliant of patients. It would seem, therefore, that 16 out of the original 38 patients (42%) have done rather well.

It would be helpful to know what placebo was used, and whether the 20% aluminium chloride hexahydrate was dissolved in absolute alcohol as used by Scholes *et al.*¹ with whose study the authors have compared their results.

We have achieved satisfactory results with outpatients by asking them to apply an aqueous solution of 20% aluminium chloride hexahydrate twice weekly at night. Using this regimen we have had few complaints of local irritation.

Finally, in comparing a medical treatment with surgery, it would seem only fair to mention the failure rate and possible morbidity and mortality of the procedure described.

Perhaps the most important conclusion that can be drawn from this report is that the treatment of axillary hyperhidrosis should be left to the physicians.

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¹ Scholes KT, Crow KD, Ellis JP, Harman RR, Saiman EM. *Br Med J* 1978;iii:84-5.

* * * We sent this letter to Mr Rayner, whose reply is printed below.—Ed, *BMJ*.

SIR,—Unfortunately your correspondent seems to have missed the point of our paper on axillary hyperhidrosis (10 May, p 1168).

Firstly, it was not our intention to deny that aluminium chloride hexahydrate could be effective, and indeed we use it ourselves in some patients with considerable success. Scholes *et al.* suggested that surgery was no longer indicated in this condition and we have identified a group of patients in whom it is still necessary. Secondly, Dr Tucker says that 16 out of 38 patients have done rather well. It is stated quite clearly in our paper that by six months 26 out of 38 patients had opted for surgery—that is,

they were given the choice of continuing with the aluminium chloride hexahydrate or having surgery. Thirdly, we stated categorically that our methods were the same as Scholes *et al.* and thus the aluminium chloride hexahydrate was dissolved in absolute alcohol.

Your correspondent also suggests that we were comparing medical treatment with surgery and again I must say that he does not appear to have read our paper carefully. We very particularly pointed out the differences between our patients and those of Scholes *et al.* Obviously the two groups were not strictly comparable. The purpose of our paper was to rectify the untrue statement in Scholes's paper that surgery was no longer indicated. With regard to Dr Tucker's point that the treatment of axillary hyperhidrosis should be left to the physicians, I would reply that it would be the utmost pleasure to leave it to them were it not for the fact that there are indeed some patients who require surgery despite their best efforts.

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School screening for scoliosis

SIR,—Mr Robert A Dickson and his colleagues are to be congratulated on the excellence of their article "School screening for scoliosis" (26 July, p 265), but I think that no work on school screening for scoliosis is complete without some reference to the studies in Greece of Smyrnis,¹ who reported last year the incidence of the idiopathic type of scoliosis to be 6.2% among young girls from Evia, whereas it was only 2.5% amongst similar girls on the island of Lesbos and only 2.4% on Chios. The implications of this are important alike for those studying the results of school screening (by whatever method) and for those of us who believe that the "idiopathic" type of scoliosis is really congenital in origin.

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¹ Smyrnis P. In: Zorab PA, Siegler D, eds. *Scoliosis: proceedings of a sixth symposium*. London: Academic Press, 1980:13-18.

Mild asymptomatic hyperparathyroidism

SIR,—We were interested to read the leading article on mild asymptomatic hyperparathyroidism (19 July, p 174). It is obviously difficult to be certain that a case is truly "asymptomatic": many vague symptoms may be overlooked by the patient or may be discounted as being irrelevant to the disease. Yet symptoms such as confusion in the elderly may be caused or exaggerated by primary hyperparathyroidism and are relieved when the disease is cured.¹ Furthermore, there is a definite risk, however small, of patients with untreated primary hyperparathyroidism developing serious complications such as renal failure² and bone disease.³

In skilled hands the risks and postoperative complications of parathyroid surgery are negligible. We therefore feel that surgery is indicated in all cases of primary hyperparathyroidism unless there is a definite contra-indication.

With the use of a reliable radioimmunoassay

for parathyroid hormone estimation, the diagnosis of primary hyperparathyroidism is relatively straightforward: the demonstration of inappropriate parathyroid hormone secretion in the face of hypercalcaemia confirms the diagnosis. In our view, the use of indirect and less reliable tests for hyperparathyroidism, such as steroid suppression tests,¹ is unnecessary. We wholeheartedly agree with the sentiment that intensive and long-term follow-up of patients with hypercalcaemia, which is mandatory, may prove to be at least as costly as parathyroid surgery.

We therefore recommend that all patients with asymptomatic hypercalcaemia be referred to specialist centres with full facilities both for the investigation of calcium metabolism and for expert parathyroid surgery.

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¹ Heath DA, Wright AD, Barnes AD, Oates GD, Dorricott NJ. *Br Med J* 1980;280:1406-8.

² Purnell DC, Scholz DA, Smith LH, et al. *Am J Med* 1974;56:800-9.

³ Habener JF, Potts JT. In: Avioli LV, Krane SM, eds. *Metabolic bone disease*, vol 2. New York: Academic Press, 1977:1-147.

⁴ Watson L, Moxham J, Fraser P. *Lancet* 1980;i:1320-5.

Pre-employment medical examinations

SIR,—I have read with interest the letters of Dr J W Todd (19 July p 232), Dr G H Sylvester (28 June, p 1616), and more recently Dr F H Tyrer (2 August, p 391).

In the first place I agree very much with Dr Tyrer that it is necessary at times to reject an applicant for nursing and certainly it is kinder to do this at the onset of training. Unfortunately we continue to see trained nurses incapacitated by chronic back disorders which should have been foreseen by careful pre-employment selection.

Perhaps more important is the fact that pre-employment medical assessment seems to be viewed as a clearcut "pass or fail" procedure. I suspect that some of this may be a relic of the Forces medical examination. Working as an occupational health physician for the area health authority and the local authority for many years, I have conducted many pre-employment medical assessments and found only a handful of those examined to be unfit for work. I do agree with Dr Tyrer that only firm medical and occupational considerations should lead to rejection. More important than the question of accepting or rejecting applicants is the selection of those cases where either on account of the requirements of the work, the medical condition of the applicant, or both, it is felt worthwhile to accept the individuals for employment subject to carrying out regular reviews of them with the aim of keeping them at work in an optimal state of physical and mental health. Surely this is the essence of good occupational medicine. Regrettably, it is still not recognised by some employing authorities that an occupational health adviser requires no less expertise than any other medical specialist.

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Research and risk

SIR,—May I comment on your leading article "Research and risk" (14 June, p 1391), which seems to be incorrect on two points—at least according to published information?

(1) "The system whereby the DHSS provided clinical resources for research has lapsed through lack of money." According to the DHSS *Handbook of Research and Development* 1978, "From 1 April 1978 full responsibility for the administration of the scheme [locally organised research scheme] was devolved to health authorities. A sum of £2.4 million will be distributed to health authorities in 1978/79 by means of additions to authorities' revenue cash limits to enable them to maintain a level of local investment in research consistent with the effort of previous years." It would be interesting to know whether this scheme has indeed lapsed with the individual RHAs.

(2) "The cost of translating findings into practice is no longer met from DHSS development funds." The DHSS *Handbook of Research and Development* 1979 states: "Funds are available from the Department's central reserves for the trial or experimental development of new techniques or services within the National Health Service, which have passed out of the initial research stage, but which need to be evaluated before they can be adopted generally. . . . In 1978/79 these contributions amounted to over £600 000 capital and approximately £500 000 revenue." Has this scheme in fact ceased?

Your leading article briefly mentions, perhaps too briefly, the problems of the doctor who wishes to do a spell of research without being penalised if he returns to the clinical ladder. It seems quite wrong that the increasingly rigid requirements of the clinical training scheme should make taking time for a period in research so difficult. One drawback is the possible loss of one or two years of NHS pension rights; but surely this should be taken care of by transfer arrangements if a research worker temporarily leaves the NHS. The clinical rat race should not be allowed to steamroller originality; if it continues to do so, bright students are likely to turn increasingly elsewhere for careers.

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Contraception and the under-16s

SIR,—I read with interest a possible defence by your legal correspondent (26 July, p 318) for a doctor finding himself prosecuted by a parent who has discovered his child in receipt of the contraceptive pill without his knowledge and consent.

Some bias and hence interpretation in this matter is understandable as he is advocating a hypothetical defence, but until there is a suitable test case the matter remains one of opinion. It cannot be at all reassuring that as a matter of public policy the police would be unlikely to take action. Public policy may well change.

I would urge all medical practitioners to have some sensibility and feeling for the well-intentioned, responsible parent who may find his child encouraged to have sexual intercourse because of the ready availability of contraception. At 15 years of age at best she is adolescent, immature, feckless, and in grave peril from the social and medical complications of sex.

Doctors should not be autonomous in matters which are not strictly medical. The law is specific that girls under 16 need protection. When there is good, sound medical evidence that sex for 12-15-year-olds is beneficial and not harmful and the minimum age of consent has been changed by informed debate and public opinion, then is the time to change prescribing practice.

Such medical autonomy as is practised by many well-intentioned doctors today is no more than anarchy, and in a respectable profession is all the more reprehensible.

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A computer in every surgery?

SIR,—I read your leading article (28 June, p 1556) "A computer in every surgery?" with great interest since we are ourselves involved with a computer system for general practice, CLINICS. We have collected five and a half years' detailed clinical and patient information. I believe that your article contains several important points that are perhaps not sufficiently realised by people in the field today. For instance, you say a computer does not automatically improve research, and you emphasise that what comes out of computers is only as good as what goes in.

Although these two facts are usually true the second can be modified, as our experience has shown. On looking at a sizable sample of our data we found a raw error rate of the order of 10%. This is the level of errors that the computer-held information would contain if it had been accepted with no checks. The actual rate of errors in our stored data has been estimated to be around 1%.¹ This significant reduction has been achieved by employing the following: (1) Sensitive error checks, specially designed for the messy and error-ridden data generated in general practice. A list of our checks is given by Basden and Clark.¹ (2) Mechanisms that positively encourage error correction. CLINICS normally refuses to accept any more data until the errors are dealt with, but it does meet the user half way by offering powerful interrogation facilities to aid his or her decision. In this way error correction is not a cumbersome chore that is easily "forgotten" when one is busy. (3) The ability to make corrections not only in the incoming data but also in the data already stored where an error has escaped detection first time round. With this facility we are able to reverse the normal tendency of information to deteriorate with time; our information becomes more accurate the more we put in.

It is significant that the initial 10% error rate is made up of 3% due to computer processing, 3% due to unclear writing, and 4% caused by the GPs themselves. Thus we have been able to overcome not only the errors generated by the complications of having a computer but also many of the errors which GPs are producing all the time but normally go unnoticed. Therefore when a computer system has the above three characteristics it is not strictly true that "what comes out of computers is only as good as what goes in." Unfortunately, however, few GP systems have all these; most fall down on the first in particular, so your comment certainly appears applicable to them.